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Proposed Minimum Care Coordination Standards for the Integrated Care Demonstration – DRAFT – 4/01/13

Statement of Values:

The State of Connecticut has a strong policy preference for person-centeredness in all care coordination activities. For the purpose of the Demonstration, person-centeredness is defined as an approach that:

- provides the Medicare/Medicaid Eligible individual (MME) with needed information, education and support required to make fully informed decisions about his or her care options and, to actively participate in his or her self-care and care planning;
- supports the MME, and any representative(s) whom he or she has chosen, in working together with his or her non-medical, medical and behavioral health providers and care manager(s) to obtain necessary supports and services; and
- reflects care coordination under the direction of and in partnership with the MME and his/her representative(s); that is consistent with his or her personal preferences, choices and strengths; and that is implemented in the most integrated setting.

Further, the State of Connecticut is committed to remedying barriers that have historically been and are currently being faced by MMEs, including barriers related to ethnicity, disability, culture, and values concerning health care that depart from the “norm”. Non-exclusive examples of these include the following:

- MMEs with physical disabilities and Serious and Persistent Mental Illness (SPMI) report being treated differently on the basis of these disabilities and/or stigma associated with these disabilities.
- Individuals with intellectual disabilities report that providers do not always take their complaints or reports of symptoms seriously.
- Homeless individuals face unique barriers in accessing primary preventative care, managing chronic conditions and receiving support with recovery from acute events.

Further, the State of Connecticut is committed to addressing the needs of individuals who may face barriers of access relating to communication (e.g. language of origin other than English, lack of reliable means of contact, housing impermanency), cognitive impairment (e.g. Alzheimer’s or other dementia, Acquired Brain Injury), lack of transportation, and/or functional limitation.

Health Neighborhoods (HNs) must commit to the principles of and indicate the means by which they will promote and evaluate the applied practice of person-centeredness. Further, HN’s must illustrate the strategies that they will employ to address the types of barriers identified above.

Definitions:

- **Assessment:** For purposes of the Demonstration, an Assessment is a comprehensive, multi-dimensional assessment of domains including functional capacity, physical and cognitive status, formal and informal supports, and environment, which is used to prepare a Plan of Care.

- **Care Coordination:** Care coordination is a person-centered, assessment-based interdisciplinary approach to integrating health care and social support services in which an individual's needs and preferences are assessed, a comprehensive care plan is developed, and services are managed and monitored by an identified care coordinator following evidence-based standards of care. Care coordination support is offered to MMEs along a continuum from minimal level of assistance to intensive level of assistance, as described by the following:
 - **Level 1 Targeted Outreach:** Targeted Outreach is a brief, focused support focused upon MMEs with unmet or underserved medical, behavioral health, LTSS or social support needs who either 1) are not at high risk; or 2) prefer to self-direct their own services and supports. This service can be provided either by a Lead Care Manager or can be delegated as appropriate to an extender (e.g. care manager assistant, community health or outreach liaison). Non-exclusive examples of Targeted Outreach include 1) assistance in identifying and scheduling appointments with specialists; 3) referrals to social services and supports; and/or 4) support with general information & assistance inquiries. Key goals of targeted outreach include providing needed information and improving access to services and supports.
 - **Level 2 Care Management:** Care Management is a periodic, intermittent support focused upon MMEs with unmet medical, behavioral health, LTSS or social support needs who are at moderate risk. This service must be provided by a Lead Care Manager. Non-exclusive examples of Care Management activities include 1) assessment of needs to identify unmet or underserved needs; 2) engagement with the MME and members of the MME's care team to support access to needed care, assist with chronic disease self-management, and promote medication compliance; and 3) coordinate services for planned care transitions (e.g. scheduled surgery or other acute treatment). Key goals of Care Management include 1) preserving and/or improving function; 2) preventing exacerbation of presenting conditions; 3) averting crises; and 4) diverting MMEs from use of emergency departments, inpatient hospitalization and re-hospitalization, and long-term nursing home placement.
 - **Level 3 Intensive Care Management:** Intensive Care Management (ICM) is an ongoing support focused upon MMEs with unmet medical, behavioral health, LTSS or social support needs who are at high risk. This service must be provided by a Lead Care Manager. Examples of ICM activities include assistance in 1) assessment of needs to identify priorities; 2) engagement with the MME and members of the MME's care team to develop near term goals relating to acute/urgent care, coordination of services across the continuum of services and supports, and chronic disease self-management; 3) coordinate services for unplanned transitions; and 4) intervene with patterns of hospitalization and re-hospitalization, and/or inappropriate nursing home placement. Key goals of ICM include 1) stabilizing the MME's health condition; 2) achieving smooth care transitions and means of monitoring needs over time; and 3) improving the MME's capacity to self-manage chronic conditions.
- **Multi-Disciplinary Care Team:** For purposes of the Demonstration, a Multi-Disciplinary Care Team (Care Team) is defined as including an MME who is participating in the Demonstration, his/her representatives, his/her LCM and extender staff, and the group of HN provider members who are mutually supporting the needs, values and preferences of that MME. Each Care Team

is led by the MME and his/her LCM, and is composed of all relevant provider members of the HN, as well as any involved Information & Assistance Affiliates and Social Services Affiliates.

- **Plan of Care (POC):** For purposes of the Demonstration, a Plan of Care is defined as a document that is completed by a Lead Care Manager in partnership with an MME and his/her chosen representatives, which articulates the MME's goals, provides an inventory of the services that are being received by the MME, identifies the members of the MME's care coordination team, and includes action steps (e.g. toward improving communication and collaboration among MME and members of the care coordination team, effectively managing chronic disease, and preventing unnecessary hospitalization and/or nursing home placement).
- **Lead Care Manager (LCM):** An LCM is responsible for assessing, coordinating and monitoring an MME's Demonstration Plan of Care (POC) for medical, behavioral health, long-term services and supports (LTSS), and social services. A Lead Care Manager must be an APRN, RN, LCSW, LMFT or LPC and must complete Demonstration specific training.
- **Lead Care Management Agency (LCMA):** A LCMA is a Medicaid enrolled provider member of a Health Neighborhood that employs staff that meet requirements to serve as LCMs.

Capacity:

Each HN must demonstrate capacity to serve MMEs along a continuum of care coordination needs from minimal to intensive. Specifically:

- Each HN must enter into care coordination agreements with LCMA's that employ staff who meet the requisite qualifications to act as Lead Care Manager (LCM), and must proffer a list of such LCMA's in its response to the RFP. To act as an LCM, an individual must be a licensed clinician (e.g. APRN, RN, PA, LCSW, LMFT or LPC) and must following upon launch of the Demonstration, agree to complete Demonstration-specific core competency training in care coordination.
- HN's must ensure that the ratio of LCM's to MME's to whom they are providing care coordination does not exceed 1:80. HN's have the authority to substitute a more limited ratio based on the acuity and care coordination needs of a given LCM's caseload of MME's.
- HN's must ensure that LCMA's have an identified and substantiated means of telephone coverage for after hours and weekend contacts.
- Each HN must enter into standard care coordination agreements provided by the State of Connecticut with all member providers that detail terms including, but not limited to:
 1. means of communication between MME's, LCM's, primary care, specialists and other providers;
 2. means of consultation among MME's, LCM's and members of MME's' multi-disciplinary care teams;
 3. role definitions in situations of care transition (e.g. from primary care to specialist, from specialist to secondary/tertiary specialist, from setting to setting).
- For purposes of the Demonstration, it is the preference of the State of Connecticut that HN's ensure that care coordination by LCM's is provided on a conflict-free basis. The State recognizes

that some MMEs, especially those with serious and persistent mental health conditions, may have a long standing therapeutic relationship with a provider. HNs that choose to permit providers of direct service to also provide care coordination are required to attest to the means by which they will establish beneficiary protections that safeguard free and informed choice of providers and adherence to standards of medical necessity.

Role of Health Neighborhood LCMs in Educating MMEs About the Demonstration:

The State of Connecticut will identify MMEs who are participants of Medicaid home and community-based waivers, MMEs who are served by Local Mental Health Authorities (LMHA), and MMEs who are being supported by Money Follows the Person (MFP) transition coordinators, and enlist those MMEs' care managers/transition coordinators in educating MMEs about the Demonstration prior to launch. Additionally, all MMEs will receive educational materials and contacts from Xerox, identifying itself as the Department of Social Services.

Role of HN ICMs in Enrollment Process

The State of Connecticut plans to use the following means of affiliating MMEs with HNs:

MMEs who have received their primary care or behavioral health care from an HN participating provider within the twelve months preceding implementation of the Demonstration will be passively enrolled with that HN under Model 2. The Department proposes to use a "step-wise" enrollment process under which the ASOs will:

- first consider whether the individual has received care from a primary care provider (including a primary care physician, FQHC, clinic, or geriatrician), and if so, enroll on that basis;
- if not, next consider whether the individual has received care from a behavioral health care provider (including psychiatrist, psychologist or licensed clinical social worker), and if so, enroll on that basis; and if not, next consider whether the individual has received care from a specialist (including, but not limited to, a cardiologist or a nephrologist) for one or more chronic conditions, and if so, enroll on that basis."

Xerox will have primary responsibility for issuing initial notices and welcome packets to each MME who is passively enrolled in an HN. The notice will disclose:

- the benefits of participation, including, but not limited to, access to care coordination and supplemental services;
- the nature of information sharing that will occur;
- the nature of any shared savings agreement in which the HN is participating; and
- the right to opt out of participation in the HN.

The welcome packet will include a list of provider members of the HN, a list of qualified Lead Care Managers (LCMs), a description of the supplemental services that will be provided and a list of the providers that will supply them, a form identifying the MME's preferred LCM, a form documenting the MME's rights and responsibilities, and a form permitting the MME to opt out of participation in the Demonstration.

The State of Connecticut will cross match the list of MMEs who are passively enrolled in a HN with participation lists for MMEs served by the Medicaid home and community-based waivers, MMEs served

by Local Mental Health Authorities (LMHA), and MMEs served by Money Follows the Person (MFP). The State of Connecticut will then transmit lists of cross-matched individuals to Xerox, which will use this information to tailor the above described enrollment materials to identify each cross-matched individual as assigned on a preliminary basis to his or her waiver care manager, LMHA care manager or MFP transition coordinator (provided that the entity has capacity to serve as an LCM). In advance of sending these MMEs enrollment materials, Xerox will provide lists of these cross-matched MMEs, as relevant, to their waiver care manager, LMHA care manager or MFP transition coordinator. Xerox will then send enrollment materials to each cross-matched MME, and each cross-matched MME's waiver care manager, LMHA care manager or MFP transition coordinator will follow up on mailed enrollment materials with telephone and/or in-person contacts to review the materials with the MME.

Required components of this review include identifying that 1) the MME may either remain enrolled in the HN or opt out of participation, in which case reverting to participation in Model 1 (Enhanced ASO); and 2) the MME may either remain affiliated, as relevant, with his or her waiver care manager, LMHA care manager or MFP transition coordinator as his or her LCM, or instead select any other entity from the list of qualified LCMA's that is provided in the enrollment materials. The waiver care manager, LMHA care manager or MFP transition coordinator will then support the MME and his/her representatives in making these decisions, and returning to Xerox 1) the opt-out form, if the MME does not wish to participate in the Demonstration; and/or 2) the identification of LCM form, which must either indicate that the MME wishes to remain affiliated with his/her waiver or LMHA care manager or identify the qualified LCMA that the MME wishes to have serve that role. If the MME declines to complete the identification of LCM form, the waiver care manager, LMHA care manager or MFP transition coordinator shall be considered to be the MME's LCM unless and until the MME identifies a preference for an alternative qualified LCMA.

MMEs who are not affiliated with a waiver care manager, an LMHA care manager or MFP transition coordinator will receive educational materials and contacts from Xerox, identifying itself as the Department of Social Services. Xerox will follow the above required elements of contact and counseling, and will forward identification of LCM forms to all LCMA's in the HN that are selected by MMEs to serve that role.

HNs must attest to observe the following standards, and are permitted to detail innovative means of building upon these minimum requirements, especially with respect to means of safeguarding MMEs' free and informed choice of participation in a HN and of LCM.

Assessment

An LCM must complete an Assessment for each MME who has chosen that LCM.

To complete a Demonstration Assessment, an LCM must 1) populate the standard Demonstration Assessment tool with any existing assessment results (e.g. results completed by a waiver care manager) that are not more than six months old; and either a) complete any missing elements of the Demonstration Assessment by interviewing the MME and his/her preferred representatives in person; or b) if the results of an existing assessment is more than six (6) months old or there has been an intervening life event (e.g. serious illness, hospitalization, bereavement), complete the entire standard Demonstration Assessment tool by interviewing the MME and his/her preferred representatives in person. If an MME's LCM is not also serving as his or her waiver care manager, LMHA care manager, or MFP transition coordinator, the LCM shall have authority to contact and to receive assessment results from the MME's waiver care manager, LMHA care manager or MFP transition coordinator.

An LCM must conduct a Demonstration Assessment within ten (10) working days of the date on which the LCM receives notice from Xerox that the MME has either affirmed or selected that LCM as the MME's preferred LCM. As indicated above, the Demonstration Assessment must be conducted face-to-face at a time and place that is convenient to the MME and his/her representatives. All aspects of the Demonstration Assessment must be informed by the Demonstration definition of person centeredness, must focus upon goal setting by the MME, and must employ the HN's identified strategies to overcome health disparities and other barriers faced by MMEs.

The Demonstration Assessment tool will support each MME's LCM in identifying the level of care coordination support needed by the MME (e.g. Targeted Outreach, Care Coordination or Intensive Care Management). The ICM's type and incidence of care coordination support will be informed by this level of care coordination. LCMs must ensure that care coordination provided under the Demonstration connects with, but does not supplant, other sources of care coordination support including, but not limited to, waiver care coordination, LMHA care coordination, MFP transition coordination and/or Person-Centered Medical Home (PCMH) care coordination.

In addition to completing the Demonstration Assessment tool, the LCM must also discuss with the MME and his/her representatives and request that the MME or his/her proxy sign the 1) Demonstration Rights and Responsibilities form; 2) the Demonstration Informed Consent form; 3) the Demonstration Information Sharing form; and 4) the Demonstration Emergency Contact form. If in any case the MME declines to sign a form, the LCM shall indicate in writing that the MME has declined. Following completion of the Assessment, the LCM must complete the Demonstration Assessment tool and post it electronically to the secure CHN-CT portal.

HNs must attest to observe the following standards, and are permitted to detail innovative means of building upon these minimum requirements, especially with respect to strategies to support the applied practice of person-centeredness in conducting Demonstration Assessments

Development and Modification of Plans of Care

Following completion of the Assessment, the LCM must, based on the face-to-face interview with the MME and his/her representatives and the Demonstration Assessment Tool, prepare a draft Demonstration Plan of Care (POC) that details the following: 1) the MME's goals; 2) the MME's primary presenting medical conditions, behavioral conditions, and functional limitations; 3) the MME's existing sources of care coordination support; 4) other members of the MME's Multi-Disciplinary Care Team; 5) initial level of care coordination support needed by the MME; and 6) key strategies toward meeting goals, addressing gaps in care and services, self-managing conditions and functional limitations, and anticipating and managing care transitions. It is imperative that the initial Demonstration Plan of Care and subsequent Demonstration Plans of Care are informed by existing Plans of Care established by the waiver care coordinator, LMHA care coordinator, MFP transition coordinator and/or PCMH care coordinator, if applicable. The LCM must also indicate on the POC his or her recommendations for any Demonstration supplemental services that may be of benefit to the MME.

The LCM must within the time frame established for the Demonstration then share the draft Demonstration POC with the MME and his/her representatives and solicit his or her feedback for enhancements or revisions. If the MME and his/her representatives agree that the Demonstration POC reflects the MME's values and preferences, the LCM must ask the MME to sign the Demonstration POC indicating approval. If the MME and his/her representatives offer feedback for enhancements or

revisions, the LCM must modify the Demonstration POC and share the revised copy with the MME and his/her representatives for signature indicating approval.

The LCM must then electronically post the MME's approved Demonstration POC to the CHN-CT secure portal.

At a minimum frequency of each six (6) months, and as often as is clinically indicated if the MME has experienced an intervening life event (e.g. serious illness, hospitalization, bereavement), the LCM must meet face-to-face with the MME and his/her representatives to determine whether any modifications or enhancements of the Demonstration POC are necessary and to determine whether the level of care coordination support that is being provided continues to be consistent with the MME's needs and preferences. If the MME's level of care coordination support requires adjustment; either to reduce the level of interaction due to improvement in health status or other indicators, or to increase the level of interaction due to such events as an illness or care transition; the LCM must document such change on the updated Demonstration POC. The LCM's type and incidence of support must be informed ongoing by the requirements for that new level of care coordination support.

HNs must attest to observe the following standards, and are permitted to detail innovative means of building upon these minimum requirements, especially with respect to strategies to support the applied practice of person-centeredness in development of POCs.

Care Coordination

Once the MME, his/her preferred representatives and his or her LCM have mutually developed a Demonstration POC, the LCM shall for purposes of the Demonstration act as the Single Point of Contact for purposes of communicating with MMEs and coordinating their services and supports. Each LCM shall for purposes of the Demonstration be guided in his/her level of care coordination support for each MME by the level of care coordination support identified with the MME and his/her representatives through the Demonstration Assessment.

The LCM shall utilize the secure messaging function available through the CHN-CT to communicate with members of the Care Team. Non-exclusive examples of the types of communications that the LCM is expected to make include 1) referrals to HN providers; 2) requests to start, modify, suspend or terminate medical, behavioral health, long-term services, supplemental services and/or social services; 3) information on changes in health status; 3) information on care transitions; and/or 4) need for collaborative problem-solving with the MME to address an emerging issue.

The LCM shall on behalf of the MME and his/her preferred representatives order any supplemental services that are indicated in the POC, and shall modify, suspend, or terminate such service at the request of the MME or where indicated by an event such as a change in health status or care transition.

The type and frequency of care coordination support that an LCM is providing to each MME must be informed by the level of care coordination support that the MME requires. The requirements listed below should be considered to be a minimum set on which the HN is permitted to build.

- **Level 1 Targeted Outreach:** Targeted Outreach is a brief, focused intervention that is provided on an as-needed or situational basis. Targeted Outreach can be provided either by a Lead Care Manager or can be delegated as appropriate to an extender (e.g.

care manager assistant, community health or outreach liaison). Non-exclusive examples of Targeted Outreach include 1) assistance in identifying and scheduling appointments with specialists; 2) assistance in locating and procuring transportation; 3) referrals to social services supports; and/or 4) support with general information & assistance inquiries. LCMs must observe the following standards in providing Targeted Outreach:

1. LCMs, or qualified proxies, must respond to telephone or other contacts received from MMEs during business hours (8:30 a.m. – 5:00 p.m.) on business days (Monday through Friday) by the close of the business day on which they are received.
2. LCMAs' after hours/weekend back-up system must ensure that telephone or other contacts received from MMEs after hours or on weekends are routed to their LCMs and that urgent matters are responded to on the day on which they are received, and non-urgent matters are responded to by the close of the next business day following the contact.

The LCM must document the types of Targeted Outreach that he/she is providing to the MME on the MME's Demonstration Plan of Care.

- **Level 2 Care Management:** Care Management is a periodic, intermittent support. This service must be provided by a Lead Care Manager. Non-exclusive examples of Care Management activities include 1) assessment of needs to identify unmet or underserved needs; 2) engagement with the MME and members of the MME's care team to support access to needed care, assist with chronic disease self-management, and promote medication compliance; and 3) coordinate services for planned care transitions (e.g. scheduled surgery or other acute treatment). LCMs must observe the following standards in providing Care Coordination:

1. LCMs, or qualified proxies, must respond to telephone or other contacts received from MMEs during business hours (8:30 a.m. – 5:00 p.m.) on business days (Monday through Friday) by the close of the business day on which they are received.
2. LCMAs' after hours/weekend back-up system must ensure that telephone or other contacts received from MMEs after hours or on weekends are routed to their LCMs and that urgent matters are responded to on the day on which they are received, and non-urgent matters are responded to by the close of the next business day following the contact.
3. LCMs must coordinate contacts with the MME, his/her preferred representatives and members of the care team to identify immediate and near-term strategies in support of meeting the MME's needs. If the LCM is not also the MME's waiver care manager, LMHA care manager or MFP transition coordinator, that individual should be considered to be an essential member of the care team. The LCM must consult with the MME and his/her preferred representatives to determine the composition of the care team most relevant to the MME's needs.
4. LCMs and members of the MME's care team must observe requirements of the Demonstration care coordination contracts in: a) means of communication between MMEs, LCMs, primary care, specialists and other providers; b) means

of consultation among MMEs, LCMs and members of MMEs' multi-disciplinary care teams; and c) role definitions in situations of care transition (e.g. from primary care to specialist, from specialist to secondary/tertiary specialist, from setting to setting).

The LCM must document the types of Care Coordination that he/she is providing to the MME on the MME's Demonstration Plan of Care.

- **Level 3 Intensive Care Management:** Intensive Care Management (ICM) is an ongoing support focused upon MMEs with unmet medical, behavioral health, LTSS or social support needs who are at high risk. This service must be provided by a Lead Care Manager. Examples of ICM activities include assistance in 1) assessment of needs to identify priorities; 2) engagement with the MME and members of the MME's care team to develop near term goals relating to acute/urgent care, coordination of services across the continuum of services and supports, and chronic disease self-management; 3) coordinate services for unplanned transitions; and 4) intervene with patterns of hospitalization and re-hospitalization, and/or inappropriate nursing home placement. LCMs must observe the following standards in providing Care Coordination:

1. LCMs, or qualified proxies, must respond to telephone or other contacts received from MMEs during business hours (8:30 a.m. – 5:00 p.m.) on business days (Monday through Friday) by the close of the business day on which they are received.
2. LCMAs' after hours/weekend back-up system must ensure that telephone or other contacts received from MMEs after hours or on weekends are routed to their LCMs and that urgent matters are responded to on the day on which they are received, and non-urgent matters must be responded to by the close of the next business day following the contact.
3. LCMs must coordinate contacts with the MME, his/her preferred representatives and members of the care team to identify immediate and near-term strategies in support of meeting the MME's needs. If the LCM is not also the MME's waiver care manager, LMHA care manager or MFP transition coordinator, that individual should be considered to be an essential member of the care team. The LCM must consult with the MME and his/her preferred representatives to determine the composition of the care team most relevant to the MME's needs.
4. LCMs and members of the MME's care team must observe requirements of the Demonstration care coordination contracts in: a) means of communication between MMEs, LCMs, primary care, specialists and other providers; b) means of consultation among MMEs, LCMs and members of MMEs' multi-disciplinary care teams; and c) role definitions in situations of care transition (e.g. from primary care to specialist, from specialist to secondary/tertiary specialist, from setting to setting).

The LCM must document the types of Intensive Care Management that he/she is providing to the MME on the MME's Demonstration Plan of Care.

HNs must attest to observe the above standards, and are permitted to detail innovative means of building upon these minimum requirements.